NHSC/State Loan Repayment Program
Primary Care Health Professional Application

Instructions for Submitting an Application

- Before submitting an application, please speak with the Human Resources unit or Recruiter at your perspective site to ensure that they are willing to participate in the program with you.
- Applications will only be accepted during the annual application period, August 1 through October 1. Applications postmarked after the deadline (October 1) will not be accepted.
- The current fiscal year application form must be used for submission. The form title includes the current grant period. If you have an application from a previous grant period, please go to www.oshpd.ca.gov/HWCDD/stateloan/index.htm to access the most current application.
- The completed application package must include:
  - A cover letter from the practice site verifying applicant's employment and agreeing to match the award amount;
  - Personal Statements, Part F of the application; and
  - Copy of current lender statements (dated within 1 month of application submission) for each loan to be included in the loan repayment. The lender statement must include the applicant's name and the mailing address of the lender.
- Mail application package to: OSHPD/HWCDD
  State Loan Repayment Program
  Attn: Sondra Jacobs
  1600 9th Street, Room 440
  Sacramento, CA 95814
- Applications received during the open application period will be ranked according to the evaluation criteria:
  - Training or work experience in a medical, dental or mental health underserved area,
  - Cultural competency training and/or work experience, and
  - Fluency in a second language.

  Other factors that may be relevant in the selection are:
  - Geographic distribution of SLRP awardees,
  - Distribution by discipline (Primary Care Physicians, Dentists, Mental Health Providers, and Mid-level Providers),
  - Area of greatest unmet need, and
  - Rural vs. Urban award distribution.
- Please do not call to inquire about the status of your application. Notification of award will be sent out within 6 weeks of the end of the application period.
- If you would like to be notified when your application is received, please include a self-addressed stamped post card or envelope with your application.
- If you have questions regarding the application, scoring criteria, or eligibility, please e-mail the program administrator at SLRP@oshpd.ca.gov.

NHSC/State Loan Repayment Program
Primary Care Health Professional Application

2007/2008 Grant Period

Please refer to the application instructions before you begin. Complete each part of the application form. Make sure all supporting documents are submitted with your application. Applications must be postmarked by the application deadline. Late applications will not be evaluated.

PART A: PERSONAL INFORMATION

Applicant's Name: _____

Mailing Address: _____

City: _____ **County**: _____ **State**: _____ **Zip**: _____

Phone Numbers (provide at least 2): (____)_____ **Hm** ☐ **Wk** ☐ **Cell** ☐

(____)_____ **Hm** ☐ **Wk** ☐ **Cell** ☐

(____)_____ **Hm** ☐ **Wk** ☐ **Cell** ☐

E-mail address (provide at least 1): _____ **Wk** ☐ **Personal** ☐

_____ **Wk** ☐ **Personal** ☐

Social Security Number: _____ **CA Drivers License/ID:** _____

Date of Birth: _____ **Gender:** **Male** ☐ **Female** ☐

Race/Ethnicity:

American Indian or Alaska Native	☐	**Hispanic or Latino**	☐
Asian	☐	**Native Hawaiian or Other Pacific Islander**	☐
Black or African American	☐	**White or Caucasian**	☐
Other*	☐		

***Please specify:** _____

List languages you speak, read, and or write in addition to English (check all that apply):

1. _____ **Speak** ☐ **Read** ☐ **Write** ☐ **Basic medical training** ☐
2. _____ **Speak** ☐ **Read** ☐ **Write** ☐ **Basic medical training** ☐
3. _____ **Speak** ☐ **Read** ☐ **Write** ☐ **Basic medical training** ☐

PART B: QUALIFICATIONS AND ELIGIBLITY

1. **Are you a United States citizen?** **Yes** ☐ **No** ☐
2. **Do you have a current and unrestricted California license to practice your profession?** **Yes** ☐ **No** ☐
3. **Do you owe an existing service obligation to another entity?** **Yes** ☐ **No** ☐
   (If yes, please provide explanation in your personal statements, Part F of this application)
4. **Are you free of judgments arising from Federal debt?** **Yes** ☐ **No** ☐
   (If no, please provide explanation in your personal statements, Part F of this application)
5. **Are you delinquent with any court ordered child support?** **Yes** ☐ **No** ☐
   (If yes, please provide explanation in your personal statements, Part F of this application)

PART C: HEALTH PROFESSION INFORMATION

MD ☐ **DO** ☐
(Indicate primary specialty)
Family Physician ☐
General Internist ☐
General Pediatrician ☐
Obstetrician-Gynecologist ☐
General Psychiatrist ☐

Physician Assistant ☐
Nurse Practitioner ☐
Certified Nurse-Midwife ☐

Dentist (D.D.S) ☐
Dentist (D.M.D) ☐
Dental Hygienist ☐

Clinical/Counseling Psychologist ☐
Licensed Clinical Social Worker ☐
Mental Health Counselor ☐
Licensed Professional Counselor ☐
Marriage and Family Therapist ☐
Psychiatric Nurse Specialist ☐

School:_____ **Date of Graduation:** _____

City: _____ **State:** _____ **Zip:** _____

Postgraduate Training: _____ **Year Completed:** _____

Board Eligible: ☐ **Board Certified:** ☐ **California License Number:** _____

Certificate Number: _____

PART D: PRACTICE SITE

1. Applicant agrees to provide full-time 40 hrs/wk (including a minimum of 32 hours of direct patient care) at:

*** Practice Site:**_____ **Percentage of time:** _____

Address: _____

City: _____ **County:** _____ **Zip +4:** _____

Practice Site Contact Person: _____

Title: _____ **Telephone Number:** (_____) _____

*** Practice Site:**_____ **Percentage of time:** _____

Address: _____

City: _____ **County:** _____ **Zip +4:** _____

Practice Site Contact Person: _____

Title: _____ **Telephone Number:** (_____) _____

2. Applicant agrees to provide full-time direct patient care, at the site(s) named above for:

2 years ☐ **3 years** ☐ **4 years** ☐

PART E: EDUCATIONAL DEBT REPORTING

- **List source and amounts of outstanding educational loans used to finance your education.**
- **You must submit evidence of the educational debts listed below (i.e. current statements for referenced accounts which include the current balance, account number, your name, and address to which payment is submitted.)**

1. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

---

2. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

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3. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

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4. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

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5. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

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6. Lender Name: _____

Lender Address (send payments to): _____

City: _____ **State:** _____ **Zip +4:** _____

Account Number: _____ **Current Loan Balance $** _____

PART F: PERSONAL STATEMENTS

Attach your personal statements to the application. Your statements must be typed. Restate and number each question along with your answer.

1. **Describe the types of training or work experience you have had in a medical, dental, or mental health underserved area.**
2. **Describe any cultural competency training and or experience you may have (include number of units completed in college or CME).**
3. **Why do you want to participate in the NHSC/State Loan Repayment Program?**
4. **If applicable, explanations for questions answered in Part B of this application.**

PART G: APPLICATION CERTIFICATION

I certify that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct and that I am willing to sign, or have signed a written agreement with a practice setting committing to a minimum two years of full-time practice. I authorize representatives of the Office of Statewide Health Planning and Development to contact educational institutions I attended, institutions holding any of the listed educational loans, and employers to verify the accuracy of the information contained in this application.

Signature: _____ **Date:** _____

Please submit your completed application, and relevant loan statements, via your practice site contact person.

MEMORANDUM OF UNDERSTANDING (MOU) INFORMATION (To be filled out by the practice site)

Please provide the name of the clinic or parent agency that will enter into a memorandum of understanding with the Office of Statewide Health Planning and Development.

Clinic or Parent Agency:_____

Address: _____

City: _____ **County:** _____ **Zip +4:** _____

Contact Person (person who will sign MOU):_____

Title: _____ **Telephone Number: (_____)** _____

Submit application and required documents to:

OSHPD/HWCDD
State Loan Repayment Program
Attn: Sondra Jacobs
1600 9th Street, Rm. 440
Sacramento, CA 95814

For Official Use Only:

Application Rec'd: _____ **Post Mark Date:** _____ **Reviewed by:** _____

Application: Complete ☐ **Incomplete** ☐ **Applicant cleared by: NHSC** ☐ **HPEF** ☐

Practice Site on File ☐ **Census Tract Number:**_____ **HPSA ID #** _____ **HPSA Score** _____

A/D ☐ **Northern** ☐ **Central** ☐ **Southern** ☐ **Urban** ☐ **Rural** ☐ **Frontier** ☐

Comments: